State of Georgia
Disproportionate Share Hospital (DSH) Examination Survey Part I
For State DSH Year 2019

DSH Version 6.00 2/21/2020

A. General DSH Year Information

	Begin	End
1. DSH Year:	07/01/2018	06/30/2019

2. Select Your Facility from the Drop-Down Menu Provided: COFFEE REGIONAL MEDICAL CENTER

Identification of cost reports needed to cover the DSH Year:

	Cost Report Begin Date(s)	Cost Report End Date(s)	
3. Cost Report Year 1	01/01/2019	12/31/2019	Must also complete a separate survey file for each cost report period listed - SEE DSH SURVEY PART II FILES
4. Cost Report Year 2 (if applicable)			
5. Cost Report Year 3 (if applicable)			

	Data
6. Medicaid Provider Number:	000000448A
7. Medicaid Subprovider Number 1 (Psychiatric or Rehab):	0
8. Medicaid Subprovider Number 2 (Psychiatric or Rehab):	0
9. Medicare Provider Number:	110089

B. DSH OB Qualifying Information

Questions 1-3, below, should be answered in the accordance with Sec. 1923(d) of the Social Security Act.

During the DSH Examination Year:	DSH Examination Year (07/01/18 - 06/30/19)
1. Did the hospital have at least two obstetricians who had staff privileges at the hospital that agreed to provide obstetric services to Medicaid-eligible individuals during the DSH year? (In the case of a hospital located in a rural area, the term "obstetrician" includes any physician with staff privileges at the hospital to perform nonemergency obstetric procedures.)	Yes
2. Was the hospital exempt from the requirement listed under #1 above because the hospital's inpatients are predominantly under 18 years of age?	No
3. Was the hospital exempt from the requirement listed under #1 above because it did not offer non-emergency obstetric services to the general population when federal Medicaid DSH regulations were enacted on December 22, 1987?	No
3a. Was the hospital open as of December 22, 1987?	Yes
3b. What date did the hospital open?	9/1/1953

C. Disclosure of Other Medicaid Payments Received:

1. **Medicaid Supplemental Payments for Hospital Services DSH Year 07/01/2018 - 06/30/2019** — $ 1,296,235
   (Should include UPL and non-claim specific payments paid based on the state fiscal year. However, DSH payments should NOT be included.)

2. **Medicaid Managed Care Supplemental Payments for hospital services for DSH Year 07/01/2018 - 06/30/2019**
   (Should include all non-claim specific payments for hospital services such as lump sum payments for full Medicaid pricing (FMP), supplementals, quality payments, bonus payments, capitation payments received by the hospital (not by the MCO), or other incentive payments.
   NOTE: Hospital portion of supplemental payments reported on DSH Survey Part II, Section E, Question 14 should be reported here if paid on a SFY basis.

3. **Total Medicaid and Medicaid Managed Care Non-Claims Payments for Hospital Services07/01/2018 - 06/30/2019** — $ 1,296,235

Certification:

	Answer
1. **Was your hospital allowed to retain 100% of the DSH payment it received for this DSH year? Matching the federal share with an IGT/CPE is not a basis for answering this question "no". If your hospital was not allowed to retain 100% of its DSH payments, please explain what circumstances were present that prevented the hospital from retaining its payments.**	Yes

Explanation for "No" answers:

The following certification is to be completed by the hospital's CEO or CFO:

I hereby certify that the information in Sections A, B, C, D, E, F, G, H, I, J, K and L of the DSH Survey files are true and accurate to the best of our ability, and supported by the financial and other records of the hospital. All Medicaid eligible patients, including those who have private insurance coverage, have been reported on the DSH survey regardless of whether the hospital received payment on the claim. I understand that this information will be used to determine the Medicaid program's compliance with federal Disproportionate Share Hospital (DSH) eligibility and payments provisions. Detailed support exists for all amounts reported in the survey. These records will be retained for a period of not less than 5 years following the due date of the survey, and will be made available for inspection when requested.

Hospital CEO or CFO Signature	Title	Date
	CFO	

Hospital CEO or CFO Printed Name	Hospital CEO or CFO Telephone Number	Hospital CEO or CFO E-Mail
Martin Hutson	912-384-1900	martin.hutson@coffeeregional.org

Contact Information for individuals authorized to respond to inquiries related to this survey:

Hospital Contact:	
Name	Deborah Massey
Title	Patient Financial Services Director
Telephone Number	912-383-6982
E-Mail Address	deborah.massey@coffeeregional.org
Mailing Street Address	1101 Ocilla Rd
Mailing City, State, Zip	Douglas, GA 31533

Outside Preparer:	
Name	Hal Guthrie
Title	Partner
Firm Name	Dixon Hughes Goodman
Telephone Number	404-575-8947
E-Mail Address	Hal.Guthrie@dhg.com

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D. General Cost Report Year Information 1/1/2019 - 12/31/2019

The following information is provided based on the information we received from the state. Please review this information for items 4 through 8 and select "Yes" or "No" to either agree or disagree with the accuracy of the information. If you disagree with one of these items, please provide the correct information along with supporting documentation when you submit your survey.

1. Select Your Facility from the Drop-Down Menu Provided:	COFFEE REGIONAL MEDICAL CENTER		
	1/1/2019 through 12/31/2019		
2. Select Cost Report Year Covered by this Survey (enter "X"):	X		
3. Status of Cost Report Used for this Survey (Should be audited if available):	1 - As Submitted		
3a. Date CMS processed the HCRIS file into the HCRIS database:			

	Data	Correct?	If Incorrect, Proper Information
4. Hospital Name:	COFFEE REGIONAL MEDICAL CENTER	Yes	
5. Medicaid Provider Number:	000000448A	Yes	
6. Medicaid Subprovider Number 1 (Psychiatric or Rehab):	0	Yes	
7. Medicaid Subprovider Number 2 (Psychiatric or Rehab):	0	Yes	
8. Medicare Provider Number:	110089	Yes	
Owner/Operator (Private State Govt., Non-State Govt., HIS/Tribal):	Non-State Govt.	Yes	
DSH Pool Classification (Small Rural, Non-Small Rural, Urban):	Small Rural	Yes	

Out-of-State Medicaid Provider Number. List all states where you had a Medicaid provider agreement during the cost report year:

	State Name	Provider No.
9. State Name & Number	FLORIDA STATE MEDICAID	014116100
10. State Name & Number		
11. State Name & Number		
12. State Name & Number		
14. State Name & Number		
15. State Name & Number		

(List additional states on a separate attachment)

E. Disclosure of Medicaid / Uninsured Payments Received: (01/01/2019 - 12/31/2019)

1. Section 1011 Payment Related to Hospital Services Included in Exhibits B & B-1 (See Note 1)	
2. Section 1011 Payment Related to Inpatient Hospital Services NOT Included in Exhibits B & B-1 (See Note 1)	
3. Section 1011 Payment Related to Outpatient Hospital Services NOT Included in Exhibits B & B-1 (See Note 1)	
4. **Total Section 1011 Payments Related to Hospital Services (See Note 1)**	$-
5. Section 1011 Payment Related to Non-Hospital Services Included in Exhibits B & B-1 (See Note 1)	
6. Section 1011 Payment Related to Non-Hospital Services NOT Included in Exhibits B & B-1 (See Note 1)	
7. **Total Section 1011 Payments Related to Non-Hospital Services (See Note 1)**	$-
8. **Out-of-State DSH Payments (See Note 2)**	

	Inpatient	Outpatient	Total
9. Total Cash Basis Patient Payments from Uninsured (On Exhibit B)	$ 123,492	$ 890,011	$1,013,503
10. Total Cash Basis Patient Payments from All Other Patients (On Exhibit B)	$ 386,202	$ 2,951,845	$3,338,047
11. Total Cash Basis Patient Payments Reported on Exhibit B (Agrees to Column (N) on Exhibit B, less physician and non-hospital portion of payments)	$509,694	$3,841,856	$4,351,550
12. Uninsured Cash Basis Patient Payments as a Percentage of Total Cash Basis Patient Payments:	24.23%	23.17%	23.29%

Should include all non-claim-specific payments such as lump sum payments for full Medicaid pricing, supplementals, quality payments, bonus payments, capitation payments received by the hospital (not by the MCO), or other incentive payments.

14. Total Medicaid managed care non-claims payments (see question 13 above) received applicable to hospital services	
15. Total Medicaid managed care non-claims payments (see question 13 above) received applicable to non-hospital services	
16. Total Medicaid managed care non-claims payments (see question 13 above) received	$-

Note 1: Subtitle B - Miscellaneous Provision, Section 1011 of the Medicare Prescription Drug Improvement and Modernization Act of 2003 provides federal reimbursement for emergency health services furnished to undocumented aliens. If your hospital received these funds during any cost report year covered by the survey, they must be reported here. If you can document that a portion of the payment received is related to non-hospital services (physician or ambulance services), report that amount in the section titled "Section 1011 Payments Related to Non-Hospital Services." Otherwise report 100 percent of the funds you received in the section related to hospital services.

Note 2: Report any DSH payments your hospital received from a state Medicaid program (other than your home state). In-state DSH payments will be reported directly from the Medicaid program and should not be included in this section of the survey.

F. MIUR / LIUR Qualifying Data from the Cost Report (01/01/2019 - 12/31/2019)

F-1. Total Hospital Days Used in Medicaid Inpatient Utilization Ratio (MIUR)

1.	Total Hospital Days Per Cost Report Excluding Swing-Bed (C/R, W/S S-3, Pt. I, Col. 8, Sum of Lns. 14, 16, 17, 18.00-18.03, 30, 31 less lines 5 & 6)	17,615	**(See Note in Section F-3, below)**

F-2. Cash Subsidies for Patient Services Received from State or Local Governments and Charity Care Charges (Used in Low-Income Utilization Ratio (LIUR) Calculation):

2.	Inpatient Hospital Subsidies	
3.	Outpatient Hospital Subsidies	
4.	Unspecified I/P and O/P Hospital Subsidies	
5.	Non-Hospital Subsidies	
6.	Total Hospital Subsidies	$ -
7.	Inpatient Hospital Charity Care Charges	7,933,976
8.	Outpatient Hospital Charity Care Charges	12,939,025
9.	Non-Hospital Charity Care Charges	
10.	Total Charity Care Charges	$ 20,873,001

F-3. Calculation of Net Hospital Revenue from Patient Services (Used for LIUR) (W/S G-2 and G-3 of Cost Report)

NOTE: All data in this section must be verified by the hospital. If data is already present in this section, it was completed using CMS HCRIS cost report data. If the hospital has a more recent version of the cost report, the data should be updated to the hospital's version of the cost report. Formulas can be overwritten as needed with actual data.

		Total Patient Revenues (Charges)			Contractual Adjustments (formulas below can be overwritten if amounts are known)			
11.	Hospital	$28,804,029.00			$ 19,920,688	$ -	$ -	$ 8,883,341
12.	Subprovider I (Psych or Rehab)	$0.00			$ -	$ -	$ -	$ -
13.	Subprovider II (Psych or Rehab)	$0.00			$ -	$ -	$ -	$ -
14.	Swing Bed - SNF			$0.00			$ -	
15.	Swing Bed - NF			$0.00			$ -	
16.	Skilled Nursing Facility			$0.00			$ -	
17.	Nursing Facility			$0.00			$ -	
18.	Other Long-Term Care			$0.00			$ -	
19.	Ancillary Services	$118,653,779.00	$229,653,779.00		$ 82,060,218	$ 158,827,131	$ -	$ 107,420,209
20.	Outpatient Services		$65,125,258.00			$ 45,040,225	$ -	$ 20,085,033
21.	Home Health Agency			$0.00			$ -	
22.	Ambulance	-	-	$ 4,617,010	-	-	$ 3,193,096	-
23.	Outpatient Rehab Providers			$0.00	$ -	$ -	$ -	$ -
24.	ASC	$0.00	$0.00		$ -	$ -	$ -	$ -
25.	Hospice			$0.00			$ -	
26.	Other	$0.00	$459,818.00	$2,646,093.00	$ -	$ 318,007	$ 1,830,022	$ 141,811
27.	Total	$ 147,457,808	$ 295,238,855	$ 7,263,103	$ 101,980,906	$ 204,185,363	$ 5,023,117	$ 136,530,394

29.	Total Per Cost Report	Total Patient Revenues (G-3 Line 1)	449,959,766	Total Contractual Adj. (G-3 Line 2)	311,189,386
30.	Increase worksheet G-3, Line 2 for Bad Debts NOT INCLUDED on worksheet G-3, Line 2 (impact is a decrease in net patient revenue)			+	
31.	Increase worksheet G-3, Line 2 for Charity Care Write-Offs NOT INCLUDED on worksheet G-3, Line 2 (impact is a decrease in net patient revenue)			+	
32.	Increase worksheet G-3, Line 2 to reverse offset of Medicaid DSH Revenue INCLUDED on worksheet G-3, Line 2 (impact is a decrease in net patient revenue)			+	
34.	Decrease worksheet G-3, Line 2 to remove Medicaid Provider Taxes INCLUDED on worksheet G-3, Line 2 (impact is an increase in net patient revenue)			-	
35.	Blank Recon Line OR "Decrease worksheet G-3, Line 2 to remove Charity Care Charges related to insured patients INCLUDED on worksheet G-3, Line 2 (impact is an increase in net patient revenue)"			-	
35.	Adjusted Contractual Adjustments				311,189,386
36.	Unreconciled Difference	Unreconciled Difference (Should be $0)	$ -	Unreconciled Difference (Should be $0)	$ -

G. Cost Report - Cost / Days / Charges

Cost Report Year (01/01/2019-12/31/2019) COFFEE REGIONAL MEDICAL CENTER

NOTE: All data in this section must be verified by the hospital. If data is already present in this section, it was completed using CMS HCRIS cost report data. If the hospital has a more recent version of the cost report, the data should be updated to the hospital's version of the cost report. Formulas can be overwritten as needed with actual data.

Line #	Cost Center Description	Total Allowable Cost	Intern & Resident Costs Removed on Cost Report *	RCE and Therapy Add-Back (If Applicable)		Total Cost	I/P Days and I/P Ancillary Charges	I/P Routine Charges and O/P Ancillary Charges	Total Charges	Medicaid Per Diem / Cost or Other Ratios
		Cost Report Worksheet B, Part I, Col. 26	*Cost Report Worksheet B, Part I, Col. 25 (Intern & Resident Offset ONLY)**	*Cost Report Worksheet C, Part I, Col.2 and Col. 4*	*Swing-Bed Carve Out - Cost Report Worksheet D-1, Part I, Line 26*	*Calculated*	*Days - Cost Report W/S D-1, Pt. I, Line 2 for Adults & Peds; W/S D-1, Pt. 2, Lines 42-47 for others*	*Inpatient Routine Charges - Cost Report Worksheet C, Pt. I, Col. 6 (Informational only unless used in Section L charges allocation)*		*Calculated Per Diem*
	Routine Cost Centers (list below):									
1	03000 ADULTS & PEDIATRICS	$ 15,461,303	$ -	$ -	$0.00	$ 15,461,303	22,376	$0.00		$ 690.98
2	03100 INTENSIVE CARE UNIT	$ 3,356,094	$ -	$ -		$ 3,356,094	2,132	$0.00		$ 1,574.15
3	03200 CORONARY CARE UNIT	$ -	$ -	$ -		$ -	-	$0.00		$ -
4	03300 BURN INTENSIVE CARE UNIT	$ -	$ -	$ -		$ -	-	$0.00		$ -
5	03400 SURGICAL INTENSIVE CARE UNIT	$ -	$ -	$ -		$ -	-	$0.00		$ -
6	03500 OTHER SPECIAL CARE UNIT	$ -	$ -	$ -		$ -	-	$0.00		$ -
7	04000 SUBPROVIDER I	$ -	$ -	$ -		$ -	-	$0.00		$ -
8	04100 SUBPROVIDER II	$ -	$ -	$ -		$ -	-	$0.00		$ -
9	04200 OTHER SUBPROVIDER	$ -	$ -	$ -		$ -	-	$0.00		$ -
10	04300 NURSERY	$ 1,836,732	$ -	$ -		$ 1,836,732	986	$0.00		$ 1,862.81
11		$ -	$ -	$ -		$ -	-	$0.00		$ -
12		$ -	$ -	$ -		$ -	-	$0.00		$ -
13		$ -	$ -	$ -		$ -	-	$0.00		$ -
14		$ -	$ -	$ -		$ -	-	$0.00		$ -
15		$ -	$ -	$ -		$ -	-	$0.00		$ -
16		$ -	$ -	$ -		$ -	-	$0.00		$ -
17		$ -	$ -	$ -		$ -	-	$0.00		$ -
18	Total Routine	$ 20,654,129	$ -	$ -	$ -	$ 20,654,129	25,494	$ -		
19	Weighted Average									$ 810.16

Line #		Hospital Observation Days - Cost Report W/S S-3, Pt. I, Line 28, Col. 8	Subprovider I Observation Days - Cost Report W/S S-3, Pt. I, Line 28.01, Col. 8	Subprovider II Observation Days - Cost Report W/S S-3, Pt. I, Line 28.02, Col. 8	Calculated (Per Diems Above Multiplied by Days)	Inpatient Charges - Cost Report Worksheet C, Pt. I, Col. 6	Outpatient Charges - Cost Report Worksheet C, Pt. I, Col. 7	Total Charges - Cost Report Worksheet C, Pt. I, Col. 8	Medicaid Calculated Cost-to-Charge Ratio
	Observation Data (Non-Distinct)								
20	09200 Observation (Non-Distinct)	7,879	-	-	$ 5,444,231	$2,324,962.00	$8,079,585.00	$ 10,404,547	0.523255

Line #		Cost Report Worksheet B, Part I, Col. 26	Cost Report Worksheet B, Part I, Col. 25 (Intern & Resident Offset ONLY)*	Cost Report Worksheet C, Part I, Col.2 and Col. 4		Calculated	Inpatient Charges - Cost Report Worksheet C, Pt. I, Col. 6	Outpatient Charges - Cost Report Worksheet C, Pt. I, Col. 7	Total Charges - Cost Report Worksheet C, Pt. I, Col. 8	Medicaid Calculated Cost-to-Charge Ratio
	Ancillary Cost Centers (from W/S C excluding Observation) (list below):									
21	5000 OPERATING ROOM	$5,194,847.00	$ -	$0.00		$ 5,194,847	$15,185,104.00	$36,125,653.00	$ 51,310,757	0.101243
22	5100 RECOVERY ROOM	$417,246.00	$ -	$0.00		$ 417,246	$639,738.00	$1,313,616.00	$ 1,953,354	0.213605
23	5200 DELIVERY ROOM & LABOR ROOM	$1,529,005.00	$ -	$0.00		$ 1,529,005	$1,429,060.00	$30,704.00	$ 1,459,764	1.047433
24	5300 ANESTHESIOLOGY	$224,652.00	$ -	$0.00		$ 224,652	$3,823,371.00	$3,746,697.00	$ 7,570,068	0.029676
25	5400 RADIOLOGY-DIAGNOSTIC	$2,262,200.00	$ -	$0.00		$ 2,262,200	$5,614,953.00	$23,015,891.00	$ 28,630,844	0.079013
26	5700 CT SCAN	$3,174,482.00	$ -	$0.00		$ 3,174,482	$7,029,276.00	$26,808,861.00	$ 33,838,137	0.093814
27	5800 MRI	$686,174.00	$ -	$0.00		$ 686,174	$1,270,776.00	$6,224,939.00	$ 7,495,715	0.091542
28	5900 CARDIAC CATHETERIZATION	$3,153,718.00	$ -	$0.00		$ 3,153,718	$10,454,097.00	$21,549,544.00	$ 32,003,641	0.098542
29	6000 LABORATORY	$5,146,843.00	$ -	$0.00		$ 5,146,843	$25,147,688.00	$37,814,542.00	$ 62,962,230	0.081745
30	6500 RESPIRATORY THERAPY	$1,440,369.00	$ -	$0.00		$ 1,440,369	$8,447,056.00	$3,659,097.00	$ 12,106,153	0.118978

G. Cost Report - Cost / Days / Charges

Cost Report Year (01/01/2019-12/31/2019) COFFEE REGIONAL MEDICAL CENTER

	Line #	Cost Center Description	Total Allowable Cost	Intern & Resident Costs Removed on Cost Report *	RCE and Therapy Add-Back (If Applicable)		Total Cost	I/P Days and I/P Ancillary Charges	I/P Routine Charges and O/P Ancillary Charges	Total Charges	Medicaid Per Diem / Cost or Other Ratios
31	6600	PHYSICAL THERAPY	$1,486,257.00	$ -	$0.00		$ 1,486,257	$1,078,518.00	$3,333,285.00	$ 4,411,803	0.336882
32	6800	SPEECH PATHOLOGY	$10,478.00	$ -	$0.00		$ 10,478	$162,128.00	$16,137.00	$ 178,265	0.058778
33	6900	ELECTROCARDIOLOGY	$114,437.00	$ -	$0.00		$ 114,437	$5,486,220.00	$8,212,808.00	$ 13,699,028	0.008354
34	7100	MEDICAL SUPPLIES CHARGED TO PATIENT	$5,751,146.00	$ -	$0.00		$ 5,751,146	$9,464,806.00	$17,855,478.00	$ 27,320,284	0.210508
35	7200	IMPL. DEV. CHARGED TO PATIENTS	$7,828,570.00	$ -	$0.00		$ 7,828,570	$9,502,521.00	$11,576,268.00	$ 21,078,789	0.371396
36	7300	DRUGS CHARGED TO PATIENTS	$8,413,985.00	$ -	$0.00		$ 8,413,985	$15,346,376.00	$31,026,771.00	$ 46,373,147	0.181441
37	7400	RENAL DIALYSIS	$485,682.00	$ -	$0.00		$ 485,682	$1,199,300.00	$160,152.00	$ 1,359,452	0.357263
38	9001	WOUND CARE CLINIC	$489,964.00	$ -	$0.00		$ 489,964	$0.00	$541,178.00	$ 541,178	0.905366
39	9002	INFUSION CLINIC	$341,779.00	$ -	$0.00		$ 341,779	$5,526.00	$752,215.00	$ 757,741	0.451050
40	9100	EMERGENCY	$5,652,000.00	$ -	$0.00		$ 5,652,000	$3,415,145.00	$17,822,235.00	$ 21,237,380	0.266135
41			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
42			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
43			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
44			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
45			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
46			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
47			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
48			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
49			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
50			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
51			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
52			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
53			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
54			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
55			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
56			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
57			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
58			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
59			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
60			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
61			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
62			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
63			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
64			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
65			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
66			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
67			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
68			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
69			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
70			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
71			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
72			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
73			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
74			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
75			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
76			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
77			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
78			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
79			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
80			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
81			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
82			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
83			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
84			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
85			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
86			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
87			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
88			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
89			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
90			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-

G. Cost Report - Cost / Days / Charges

Cost Report Year (01/01/2019-12/31/2019) COFFEE REGIONAL MEDICAL CENTER

	Line #	Cost Center Description	Total Allowable Cost	Intern & Resident Costs Removed on Cost Report *	RCE and Therapy Add-Back (If Applicable)		Total Cost	I/P Days and I/P Ancillary Charges	I/P Routine Charges and O/P Ancillary Charges	Total Charges	Medicaid Per Diem / Cost or Other Ratios
91			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
92			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
93			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
94			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
95			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
96			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
97			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
98			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
99			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
100			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
101			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
102			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
103			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
104			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
105			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
106			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
107			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
108			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
109			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
110			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
111			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
112			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
113			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
114			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
115			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
116			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
117			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
118			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
119			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
120			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
121			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
122			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
123			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
124			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
125			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
126		**Total Ancillary**	$ 53,803,834	$ -	$ -		$ 53,803,834	$ 127,026,621	$ 259,665,656	$ 386,692,277	
127		**Weighted Average**									0.153218
128		**Sub Totals**	$ 74,457,963	$ -	$ -		$ 74,457,963	$ 127,026,621	$ 259,665,656	$ 386,692,277	
129		NF, SNF, and Swing Bed Cost for Medicaid *(Sum of applicable Cost Report Worksheet D-3, Title 19, Column 3, Line 200 and Worksheet D, Part V, Title 19, Column 5-7, Line 200)*					$0.00				
130		NF, SNF, and Swing Bed Cost for Medicare *(Sum of applicable Cost Report Worksheet D-3, Title 18, Column 3, Line 200 and Worksheet D, Part V, Title 18, Column 5-7, Line 200)*					$0.00				
131		NF, SNF, and Swing Bed Cost for Other Payers *(Hospital must calculate. Submit support for calculation of cost.)*									
131.01		Other Cost Adjustments (support must be submitted)									
132		**Grand Total**					$ 74,457,963				
133		Total Intern/Resident Cost as a Percent of Other Allowable Cost					0.00%				

* Note A - Final cost-to-charge ratios should include teaching cost. Only enter Intern & Resident costs if it was removed in Column 25 of Worksheet B, Pt. I of the cost report you are using.

H. In-State Medicaid and All Uninsured Inpatient and Outpatient Hospital Data:

Cost Report Year (01/01/2019-12/31/2019) COFFEE REGIONAL MEDICAL CENTER

				In-State Medicaid FFS Primary		In-State Medicaid Managed Care Primary		In-State Medicare FFS Cross-Overs (with Medicaid Secondary)	
1	03000	ADULTS & PEDIATRICS	$ 690.98	1,473		1,027		1,853	
2	03100	INTENSIVE CARE UNIT	$ 1,574.15	430		9		330	
3	03200	CORONARY CARE UNIT	$ -						
4	03300	BURN INTENSIVE CARE UNIT	$ -						
5	03400	SURGICAL INTENSIVE CARE UNIT	$ -						
6	03500	OTHER SPECIAL CARE UNIT	$ -						
7	04000	SUBPROVIDER I	$ -						
8	04100	SUBPROVIDER II	$ -						
9	04200	OTHER SUBPROVIDER	$ -						
10	04300	NURSERY	$ 1,862.81	45		611			
11			$ -						
12			$ -						
13			$ -						
14			$ -						
15			$ -						
16			$ -						
17			$ -						
18			**Total Days**	1,948		1,647		2,183	
19	Total Days per PS&R or Exhibit Detail			1,948		1,647		2,183	
20		Unreconciled Days (Explain Variance)		-		-		-	
				Routine Charges		**Routine Charges**		**Routine Charges**	
21		Routine Charges		$ 1,779,991		$ 1,326,822		$ 1,991,636	
21.01		Calculated Routine Charge Per Diem		$ 913.75		$ 805.60		$ 912.34	

		Ancillary Cost Centers (from W/S C) (from Section G):		**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**
22	09200	Observation (Non-Distinct)	0.523255	244,246	1,008,865	198,294	637,391	308,900	514,190
23	5000	OPERATING ROOM	0.101243	1,192,840	2,594,591	1,520,445	4,320,142	912,497	1,439,820
24	5100	RECOVERY ROOM	0.213605	46,565	78,535	128,969	218,991	43,378	34,750
25	5200	DELIVERY ROOM & LABOR ROOM	1.047433	28,362	8,025	484,805	3,647	-	-
26	5300	ANESTHESIOLOGY	0.029676	170,376	334,653	405,577	816,502	136,152	176,414
27	5400	RADIOLOGY-DIAGNOSTIC	0.079013	671,079	1,245,784	214,374	1,826,350	850,466	1,074,893
28	5700	CT SCAN	0.093814	773,869	1,599,724	185,680	2,421,861	754,144	1,541,914
29	5800	MRI	0.091542	95,557	396,198	33,165	532,095	122,378	402,896
30	5900	CARDIAC CATHETERIZATION	0.098542	1,395,659	872,709	46,328	344,539	882,515	1,206,155
31	6000	LABORATORY	0.081745	3,269,081	2,868,496	1,317,494	4,776,761	3,715,841	2,036,803
32	6500	RESPIRATORY THERAPY	0.118978	994,381	272,381	139,888	325,704	1,096,815	273,218
33	6600	PHYSICAL THERAPY	0.336882	101,301	88,214	8,350	175,991	112,595	46,735
34	6800	SPEECH PATHOLOGY	0.058778	634	-	81,514	951	7,136	2,193
35	6900	ELECTROCARDIOLOGY	0.008354	430,194	293,296	95,309	393,055	766,463	662,273
36	7100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.210508	935,782	1,203,244	858,114	1,841,155	1,153,386	970,204
37	7200	IMPL. DEV. CHARGED TO PATIENTS	0.371396	545,343	717,764	83,339	592,206	409,203	448,561
38	7300	DRUGS CHARGED TO PATIENTS	0.181441	1,958,470	1,151,947	482,703	2,167,146	2,270,151	1,357,830
39	7400	RENAL DIALYSIS	0.357263	191,027	-	-	-	269,341	30,345

H. In-State Medicaid and All Uninsured Inpatient and Outpatient Hospital Data:

Cost Report Year (01/01/2019-12/31/2019) COFFEE REGIONAL MEDICAL CENTER

					In-State Medicaid FFS Primary		In-State Medicaid Managed Care Primary		In-State Medicare FFS Cross-Overs (with Medicaid Secondary)	
40	9001	WOUND CARE CLINIC		0.905366	-	82,994	-	4,495	-	16,662
41	9002	INFUSION CLINIC		0.451050	-	-	-	43,745	2,986	13,615
42	9100	EMERGENCY		0.266135	417,464	1,289,557	113,423	3,897,687	429,785	611,488
43				-						
44				-						
45				-						
46				-						
47				-						
48				-						
49				-						
50				-						
51				-						
52				-						
53				-						
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79				-						
80				-						
81				-						
82				-						
83				-						
84				-						

H. In-State Medicaid and All Uninsured Inpatient and Outpatient Hospital Data:

Cost Report Year (01/01/2019-12/31/2019) COFFEE REGIONAL MEDICAL CENTER

				In-State Medicaid FFS Primary		In-State Medicaid Managed Care Primary		In-State Medicare FFS Cross-Overs (with Medicaid Secondary)	
85			-						
86			-						
87			-						
88			-						
89			-						
90			-						
91			-						
92			-						
93			-						
94			-						
95			-						
96			-						
97			-						
98			-						
99			-						
100			-						
101			-						
102			-						
103			-						
104			-						
105			-						
106			-						
107			-						
108			-						
109			-						
110			-						
111			-						
112			-						
113			-						
114			-						
115			-						
116			-						
117			-						
118			-						
119			-						
120			-						
121			-						
122			-						
123			-						
124			-						
125			-						
126			-						
127			-						
				$ 13,462,230	$ 16,106,976	$ 6,397,771	$ 25,340,414	$ 14,244,131	$ 12,860,959

H. In-State Medicaid and All Uninsured Inpatient and Outpatient Hospital Data:

Cost Report Year (01/01/2019-12/31/2019) COFFEE REGIONAL MEDICAL CENTER

		In-State Medicaid FFS Primary		In-State Medicaid Managed Care Primary		In-State Medicare FFS Cross-Overs (with Medicaid Secondary)	
	Totals / Payments						
128	**Total Charges** ***(includes organ acquisition from Section J)***	$ 15,242,221	$ 16,106,976	$ 7,724,593	$ 25,340,414	$ 16,235,767	$ 12,860,959
129	Total Charges per PS&R or Exhibit Detail	$ 15,242,221	$ 16,106,976	$ 7,724,593	$ 25,340,414	$ 16,235,767	$ 12,860,959
130	Unreconciled Charges (Explain Variance)	-	-	-	-	-	-
131	**Total Calculated Cost (includes organ acquisition from Section J)**	$ 3,701,228	$ 2,642,741	$ 3,171,119	$ 3,853,598	$ 3,800,921	$ 1,845,217
132	Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)	$ 3,836,335	$ 2,255,492	$ -	$ 185	$ 341,441	$ 225,396
133	Total Medicaid Managed Care Paid Amount (excludes TPL, Co-Pay and Spend-Down) (See Note E)			$ 2,744,684	$ 3,715,980	$ -	$ -
134	Private Insurance (including primary and third party liability)	$ 89,391	$ 143,635	$ -	$ 18,199	$ 1,613	$ 6,491
135	Self-Pay (including Co-Pay and Spend-Down)		$ 6,128	$ 124	$ (395)	$ 68	$ (180)
136	Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments)	$ 3,925,726	$ 2,405,255	$ 2,744,808	$ 3,733,969		
137	Medicaid Cost Settlement Payments (See Note B)		$ (210,949)				
138	Other Medicaid Payments Reported on Cost Report Year (See Note C)						
139	Medicare Traditional (non-HMO) Paid Amount (excludes coinsurance/deductibles)					$ 3,490,476	$ 1,297,042
140	Medicare Managed Care (HMO) Paid Amount (excludes coinsurance/deductibles)					$ 14,990	$ 57,595
141	Medicare Cross-Over Bad Debt Payments					$ 58,212	$ 162,850
142	Other Medicare Cross-Over Payments (See Note D)						
143	Payment from Hospital Uninsured During Cost Report Year (Cash Basis)						
144	Section 1011 Payment Related to Inpatient Hospital Services NOT Included in Exhibits B & B-1 (from Seion E)						
145	**Calculated Payment Shortfall / (Longfall) (PRIOR TO SUPPLEMENTAL PAYMENTS AND DSH)**	$ (224,498)	$ 448,435	$ 426,311	$ 119,629	$ (105,878)	$ 96,023
146	**Calculated Payments as a Percentage of Cost**	106%	83%	87%	97%	103%	95%
147	**Total Medicare Days from W/S S-3 of the Cost Report Excluding Swing-Bed (C/R, W/S S-3, Pt. I, C. 6, Sum of Lns. 2, 3, 4, 14, 16, 17, 18 less lines 5 & 6)**					10,148	
148	**Percent of cross-over days to total Medicare days from the cost report**					22%	

H. In-State Medicaid and All Uninsured Inpatient and Outpatient Hospital Data:

Cost Report Year (01/01/2019-12/31/2019) COFFEE REGIONAL MEDICAL CENTER

				In-State Other Medicaid Eligibles (Not Included Elsewhere)	Uninsured	Total In-State Medicaid
1	03000	ADULTS & PEDIATRICS	$ 690.98	1,483	1,187	5,836
2	03100	INTENSIVE CARE UNIT	$ 1,574.15	150	217	919
3	03200	CORONARY CARE UNIT	$ -			-
4	03300	BURN INTENSIVE CARE UNIT	$ -			-
5	03400	SURGICAL INTENSIVE CARE UNIT	$ -			-
6	03500	OTHER SPECIAL CARE UNIT	$ -			-
7	04000	SUBPROVIDER I	$ -			-
8	04100	SUBPROVIDER II	$ -			-
9	04200	OTHER SUBPROVIDER	$ -			-
10	04300	NURSERY	$ 1,862.81	133	28	789
11			$ -			-
12			$ -			-
13			$ -			-
14			$ -			-
15			$ -			-
16			$ -			-
17			$ -			-
18			**Total Days**	1,766	1,432	7,544
19	Total Days per PS&R or Exhibit Detail			1,766	1,432	
20		Unreconciled Days (Explain Variance)		-	-	
				Routine Charges	**Routine Charges**	**Routine Charges**
21		Routine Charges		$ 1,518,297	$ 1,290,165	$ 6,616,746
21.01		Calculated Routine Charge Per Diem		$ 859.74	$ 900.95	$ 877.09

		Ancillary Cost Centers (from W/S C) (from Section G):		**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**
22	09200	Observation (Non-Distinct)	0.523255	312,468	1,345,176	182,043	840,131	$ 1,063,908	$ 3,505,622
23	5000	OPERATING ROOM	0.101243	1,436,016	3,063,002	1,172,116	2,288,694	$ 5,061,798	$ 11,417,555
24	5100	RECOVERY ROOM	0.213605	61,160	109,115	62,550	99,358	$ 280,072	$ 441,391
25	5200	DELIVERY ROOM & LABOR ROOM	1.047433	170,637	3,996	17,706	-	$ 683,804	$ 15,668
26	5300	ANESTHESIOLOGY	0.029676	206,160	458,305	204,518	348,347	$ 918,265	$ 1,785,874
27	5400	RADIOLOGY-DIAGNOSTIC	0.079013	674,843	2,162,495	703,173	1,962,226	$ 2,410,762	$ 6,309,522
28	5700	CT SCAN	0.093814	553,830	2,453,857	663,412	4,927,497	$ 2,267,523	$ 8,017,356
29	5800	MRI	0.091542	161,397	538,956	185,214	270,662	$ 412,497	$ 1,870,145
30	5900	CARDIAC CATHETERIZATION	0.098542	976,952	2,543,748	1,475,448	1,342,052	$ 3,301,454	$ 4,967,151
31	6000	LABORATORY	0.081745	2,632,448	3,866,557	2,643,977	5,756,384	$ 10,934,864	$ 13,548,617
32	6500	RESPIRATORY THERAPY	0.118978	772,782	434,810	484,449	333,114	$ 3,003,866	$ 1,306,113
33	6600	PHYSICAL THERAPY	0.336882	133,240	237,745	51,442	120,268	$ 355,486	$ 548,685
34	6800	SPEECH PATHOLOGY	0.058778	22,549	1,902	7,152	317	$ 111,833	$ 5,046
35	6900	ELECTROCARDIOLOGY	0.008354	583,499	1,064,482	622,497	999,912	$ 1,875,465	$ 2,413,106
36	7100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.210508	928,237	2,094,701	935,312	2,480,855	$ 3,875,519	$ 6,109,304
37	7200	IMPL. DEV. CHARGED TO PATIENTS	0.371396	786,594	1,695,645	439,892	626,510	$ 1,824,479	$ 3,454,176
38	7300	DRUGS CHARGED TO PATIENTS	0.181441	1,459,998	3,119,762	1,203,073	2,235,972	$ 6,171,321	$ 7,796,685
39	7400	RENAL DIALYSIS	0.357263	102,051	41,871	16,098	45,155	$ 562,419	$ 72,216

H. In-State Medicaid and All Uninsured Inpatient and Outpatient Hospital Data:

Cost Report Year (01/01/2019-12/31/2019) COFFEE REGIONAL MEDICAL CENTER

				In-State Other Medicaid Eligibles (Not Included Elsewhere)		Uninsured		Total In-State Medicaid	
40	9001	WOUND CARE CLINIC	0.905366	-	92,555	-	29,462	$ -	$ 196,706
41	9002	INFUSION CLINIC	0.451050	1,270	79,100	-	73,793	$ 4,256	$ 136,460
42	9100	EMERGENCY	0.266135	283,140	1,650,393	459,270	4,442,677	$ 1,243,812	$ 7,449,125
43			-					$ -	$ -
44			-					$ -	$ -
45			-					$ -	$ -
46			-					$ -	$ -
47			-					$ -	$ -
48			-					$ -	$ -
49			-					$ -	$ -
50			-					$ -	$ -
51			-					$ -	$ -
52			-					$ -	$ -
53			-					$ -	$ -
54			-					$ -	$ -
55			-					$ -	$ -
56			-					$ -	$ -
57			-					$ -	$ -
58			-					$ -	$ -
59			-					$ -	$ -
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69			-					$ -	$ -
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75			-					$ -	$ -
76			-					$ -	$ -
77			-					$ -	$ -
78			-					$ -	$ -
79			-					$ -	$ -
80			-					$ -	$ -
81			-					$ -	$ -
82			-					$ -	$ -
83			-					$ -	$ -
84			-					$ -	$ -

H. In-State Medicaid and All Uninsured Inpatient and Outpatient Hospital Data:

Cost Report Year (01/01/2019-12/31/2019) COFFEE REGIONAL MEDICAL CENTER

				In-State Other Medicaid Eligibles (Not Included Elsewhere)		Uninsured		Total In-State Medicaid	
85			-					$ -	$ -
86			-					$ -	$ -
87			-					$ -	$ -
88			-					$ -	$ -
89			-					$ -	$ -
90			-					$ -	$ -
91			-					$ -	$ -
92			-					$ -	$ -
93			-					$ -	$ -
94			-					$ -	$ -
95			-					$ -	$ -
96			-					$ -	$ -
97			-					$ -	$ -
98			-					$ -	$ -
99			-					$ -	$ -
100			-					$ -	$ -
101			-					$ -	$ -
102			-					$ -	$ -
103			-					$ -	$ -
104			-					$ -	$ -
105			-					$ -	$ -
106			-					$ -	$ -
107			-					$ -	$ -
108			-					$ -	$ -
109			-					$ -	$ -
110			-					$ -	$ -
111			-					$ -	$ -
112			-					$ -	$ -
113			-					$ -	$ -
114			-					$ -	$ -
115			-					$ -	$ -
116			-					$ -	$ -
117			-					$ -	$ -
118			-					$ -	$ -
119			-					$ -	$ -
120			-					$ -	$ -
121			-					$ -	$ -
122			-					$ -	$ -
123			-					$ -	$ -
124			-					$ -	$ -
125			-					$ -	$ -
126			-					$ -	$ -
127			-					$ -	$ -
				$ 12,259,270	$ 27,058,173	$ 11,529,342	$ 29,223,386		

H. In-State Medicaid and All Uninsured Inpatient and Outpatient Hospital Data:

Cost Report Year (01/01/2019-12/31/2019) COFFEE REGIONAL MEDICAL CENTER

		In-State Other Medicaid Eligibles (Not Included Elsewhere)		Uninsured		Total In-State Medicaid	
	Totals / Payments						
128	**Total Charges** ***(includes organ acquisition from Section J)***	$ 13,777,567	$ 27,058,173	$ 12,819,507 (Agrees to Exhibit A)	$ 29,223,386 (Agrees to Exhibit A)	$ 52,980,149	$ 81,366,522
129	Total Charges per PS&R or Exhibit Detail	$ 13,777,567	$ 27,058,173	$ 12,819,507	$ 29,223,386		
130	Unreconciled Charges (Explain Variance)	-	-	-	-		
131	**Total Calculated Cost (includes organ acquisition from Section J)**	$ 3,454,771	$ 4,423,467	$ 2,749,240	$ 4,455,352	$ 14,128,039	$ 12,765,023
132	Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)	$ 240,604	$ 202,748			$ 4,418,380	$ 2,683,821
133	Total Medicaid Managed Care Paid Amount (excludes TPL, Co-Pay and Spend-Down) (See Note E)	$ 175,763	$ 93,212			$ 2,920,447	$ 3,809,192
134	Private Insurance (including primary and third party liability)	$ 550,010	$ 950,779			$ 641,014	$ 1,119,103
135	Self-Pay (including Co-Pay and Spend-Down)	$ 1,563	$ 21,974			$ 1,755	$ 27,527
136	Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments)						
137	Medicaid Cost Settlement Payments (See Note B)					$ -	$ (210,949)
138	Other Medicaid Payments Reported on Cost Report Year (See Note C)					$ -	$ -
139	Medicare Traditional (non-HMO) Paid Amount (excludes coinsurance/deductibles)	$ 484,259	$ 1,076,316			$ 3,974,734	$ 2,373,358
140	Medicare Managed Care (HMO) Paid Amount (excludes coinsurance/deductibles)	$ 1,864,834	$ 2,224,990			$ 1,879,823	$ 2,282,585
141	Medicare Cross-Over Bad Debt Payments			(Agrees to Exhibit B and B-1)	(Agrees to Exhibit B and B-1)	$ 58,212	$ 162,850
142	Other Medicare Cross-Over Payments (See Note D)					$ -	$ -
143	Payment from Hospital Uninsured During Cost Report Year (Cash Basis)			$ 123,492	$ 890,011		
144	Section 1011 Payment Related to Inpatient Hospital Services NOT Included in Exhibits B & B-1 (from Se			$ -	$ -		
145	**Calculated Payment Shortfall / (Longfall) (PRIOR TO SUPPLEMENTAL PAYMENTS AND DSH)**	$ 137,738	$ (146,552)	$ 2,625,748	$ 3,565,341	$ 233,673	$ 517,535
146	**Calculated Payments as a Percentage of Cost**	96%	103%	4%	20%	98%	96%
147	**Total Medicare Days from W/S S-3 of the Cost Report Excluding Swing-Bed (C/R, W/S S-3, Pt. I, C**						
148	**Percent of cross-over days to total Medicare days from the cost report**						

I. Out-of-State Medicaid Data:

Cost Report Year (01/01/2019-12/31/2019) COFFEE REGIONAL MEDICAL CENTER

Line #	Cost Center Description	Medicaid Per Diem Cost for Routine Cost Centers	Medicaid Cost to Charge Ratio for Ancillary Cost Centers	Out-of-State Medicaid FFS Primary		Out-of-State Medicaid Managed Care Primary		Out-of-State Medicare FFS Cross-Overs (with Medicaid Secondary)		Out-of-State Other Medicaid Eligibles (Not Included Elsewhere)		Total Out-Of-State Medicaid	
				Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient
		From Section G	From Section G	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)		
	Routine Cost Centers (list below):			Days		Days		Days		Days		Days	
1	03000 ADULTS & PEDIATRICS	$ 690.98		1								1	
2	03100 INTENSIVE CARE UNIT	$ 1,574.15										-	
3	03200 CORONARY CARE UNIT	$ -										-	
4	03300 BURN INTENSIVE CARE UNIT	$ -										-	
5	03400 SURGICAL INTENSIVE CARE UNIT	$ -										-	
6	03500 OTHER SPECIAL CARE UNIT	$ -										-	
7	04000 SUBPROVIDER I	$ -										-	
8	04100 SUBPROVIDER II	$ -										-	
9	04200 OTHER SUBPROVIDER	$ -										-	
10	04300 NURSERY	$ 1,862.81										-	
11		$ -										-	
12		$ -										-	
13		$ -										-	
14		$ -										-	
15		$ -										-	
16		$ -										-	
17		$ -										-	
18			Total Days	1		-		-		-		1	
19	Total Days per PS&R or Exhibit Detail			1		-		-		-			
20	Unreconciled Days (Explain Variance)			-		-		-		-			
				Routine Charges		Routine Charges		Routine Charges		Routine Charges		Routine Charges	
21	Routine Charges			$ 714								$ 714	
21.01	Calculated Routine Charge Per Diem			$ 714.00		$ -		$ -		$ -		$ 714.00	
	Ancillary Cost Centers (from W/S C) (list below):			Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges
22	09200 Observation (Non-Distinct)		0.523255	1,400	1,370				3,154		563	$ 1,400	$ 5,087
23	5000 OPERATING ROOM		0.101243	-								$ -	$ -
24	5100 RECOVERY ROOM		0.213605	-								$ -	$ -
25	5200 DELIVERY ROOM & LABOR ROOM		1.047433	-								$ -	$ -
26	5300 ANESTHESIOLOGY		0.029676	-								$ -	$ -
27	5400 RADIOLOGY-DIAGNOSTIC		0.079013	815	1,105				1,573		268	$ 815	$ 2,946
28	5700 CT SCAN		0.093814	-	-				10,550		-	$ -	$ 10,550
29	5800 MRI		0.091542	-	-				-		-	$ -	$ -
30	5900 CARDIAC CATHETERIZATION		0.098542	-	-				-		-	$ -	$ -
31	6000 LABORATORY		0.081745	5,165	4,815				8,353		2,164	$ 5,165	$ 15,332
32	6500 RESPIRATORY THERAPY		0.118978	1,855	1,618				-		967	$ 1,855	$ 2,585
33	6600 PHYSICAL THERAPY		0.336882	-	-				-		-	$ -	$ -
34	6800 SPEECH PATHOLOGY		0.058778	-	-				-		-	$ -	$ -
35	6900 ELECTROCARDIOLOGY		0.008354	4,032	624				208		-	$ 4,032	$ 832
36	7100 MEDICAL SUPPLIES CHARGED TO PATIENT		0.210508	906	2,488				5,312		1,369	$ 906	$ 9,169
37	7200 IMPL. DEV. CHARGED TO PATIENTS		0.371396	-	-				-		-	$ -	$ -
38	7300 DRUGS CHARGED TO PATIENTS		0.181441	1,701	1,608				3,350		322	$ 1,701	$ 5,280
39	7400 RENAL DIALYSIS		0.357263	-	-				-		-	$ -	$ -
40	9001 WOUND CARE CLINIC		0.905366	-	-				-		-	$ -	$ -
41	9002 INFUSION CLINIC		0.451050	-	-				-		-	$ -	$ -
42	9100 EMERGENCY		0.266135	827	2,885				6,721		2,012	$ 827	$ 11,618
43			-									$ -	$ -
44			-									$ -	$ -
45			-									$ -	$ -
46			-									$ -	$ -
47			-									$ -	$ -
48			-									$ -	$ -

I. Out-of-State Medicaid Data:

Cost Report Year (01/01/2019-12/31/2019) COFFEE REGIONAL MEDICAL CENTER

					Out-of-State Medicaid FFS Primary		Out-of-State Medicaid Managed Care Primary		Out-of-State Medicare FFS Cross-Overs (with Medicaid Secondary)		Out-of-State Other Medicaid Eligibles (Not Included Elsewhere)		Total Out-Of-State Medicaid	
49				-									$ -	$ -
50				-									$ -	$ -
51				-									$ -	$ -
52				-									$ -	$ -
53				-									$ -	$ -
54				-									$ -	$ -
55				-									$ -	$ -
56				-									$ -	$ -
57				-									$ -	$ -
58				-									$ -	$ -
59				-									$ -	$ -
60				-									$ -	$ -
61				-									$ -	$ -
62				-									$ -	$ -
63				-									$ -	$ -
64				-									$ -	$ -
65				-									$ -	$ -
66				-									$ -	$ -
67				-									$ -	$ -
68				-									$ -	$ -
69				-									$ -	$ -
70				-									$ -	$ -
71				-									$ -	$ -
72				-									$ -	$ -
73				-									$ -	$ -
74				-									$ -	$ -
75				-									$ -	$ -
76				-									$ -	$ -
77				-									$ -	$ -
78				-									$ -	$ -
79				-									$ -	$ -
80				-									$ -	$ -
81				-									$ -	$ -
82				-									$ -	$ -
83				-									$ -	$ -
84				-									$ -	$ -
85				-									$ -	$ -
86				-									$ -	$ -
87				-									$ -	$ -
88				-									$ -	$ -
89				-									$ -	$ -
90				-									$ -	$ -
91				-									$ -	$ -
92				-									$ -	$ -
93				-									$ -	$ -
94				-									$ -	$ -
95				-									$ -	$ -
96				-									$ -	$ -
97				-									$ -	$ -
98				-									$ -	$ -
99				-									$ -	$ -
100				-									$ -	$ -
101				-									$ -	$ -
102				-									$ -	$ -
103				-									$ -	$ -
104				-									$ -	$ -
105				-									$ -	$ -
106				-									$ -	$ -
107				-									$ -	$ -
108				-									$ -	$ -
109				-									$ -	$ -
110				-									$ -	$ -
111				-									$ -	$ -

I. Out-of-State Medicaid Data:

Cost Report Year (01/01/2019-12/31/2019) COFFEE REGIONAL MEDICAL CENTER

				Out-of-State Medicaid FFS Primary		Out-of-State Medicaid Managed Care Primary		Out-of-State Medicare FFS Cross-Overs (with Medicaid Secondary)		Out-of-State Other Medicaid Eligibles (Not Included Elsewhere)		Total Out-Of-State Medicaid	
112			-									$ -	$ -
113			-									$ -	$ -
114			-									$ -	$ -
115			-									$ -	$ -
116			-									$ -	$ -
117			-									$ -	$ -
118			-									$ -	$ -
119			-									$ -	$ -
120			-									$ -	$ -
121			-									$ -	$ -
122			-									$ -	$ -
123			-									$ -	$ -
124			-									$ -	$ -
125			-									$ -	$ -
126			-									$ -	$ -
127			-									$ -	$ -
				$ 16,701	$ 16,513	$ -	$ -	$ -	$ 39,221	$ -	$ 7,665		

Totals / Payments

128	**Total Charges (includes organ acquisition from Section K)**	$ 17,415	$ 16,513	$ -	$ -	$ -	$ 39,221	$ -	$ 7,665	$ 17,415	$ 63,399
129	Total Charges per PS&R or Exhibit Detail	$ 17,415	$ 16,513	$ -	$ -	$ -	$ 39,221	$ -	$ 7,665		
130	Unreconciled Charges (Explain Variance)	-	-	-	-	-	-	-	-		
131	**Total Calculated Cost (includes organ acquisition from Section K)**	$ 2,884	$ 2,979	$ -	$ -	$ -	$ 6,964	$ -	$ 1,490	$ 2,884	$ 11,433
132	Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)	$ 2,267	$ 907							$ 2,267	$ 907
133	Total Medicaid Managed Care Paid Amount (excludes TPL, Co-Pay and Spend-Down) (See Note E)								$ 200	$ -	$ 200
134	Private Insurance (including primary and third party liability)								$ 33	$ -	$ 33
135	Self-Pay (including Co-Pay and Spend-Down)									$ -	$ -
136	Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments)	$ 2,267	$ 907	$ -	$ -						
137	Medicaid Cost Settlement Payments (See Note B)									$ -	$ -
138	Other Medicaid Payments Reported on Cost Report Year (See Note C)									$ -	$ -
139	Medicare Traditional (non-HMO) Paid Amount (excludes coinsurance/deductibles)						$ 5,160			$ -	$ 5,160
140	Medicare Managed Care (HMO) Paid Amount (excludes coinsurance/deductibles)									$ -	$ -
141	Medicare Cross-Over Bad Debt Payments									$ -	$ -
142	Other Medicare Cross-Over Payments (See Note D)									$ -	$ -
143	**Calculated Payment Shortfall / (Longfall) (PRIOR TO SUPPLEMENTAL PAYMENTS AND DSH)**	$ 617	$ 2,072	$ -	$ -	$ -	$ 1,804	$ -	$ 1,257	$ 617	$ 5,133
144	**Calculated Payments as a Percentage of Cost**	79%	30%	0%	0%	0%	74%	0%	16%	79%	55%

Note A - These amounts must agree to your inpatient and outpatient Medicaid paid claims summary. For Managed Care, Cross-Over data, and other eligibles, use the hospital's logs if PS&R summaries are not available (submit logs with survey).
Note B - Medicaid cost settlement payments refer to payments made by Medicaid during a cost report settlement that are not reflected on the claims paid summary (RA summary or PS&R).
Note C - Other Medicaid Payments such as Outliers and Non-Claim Specific payments. DSH payments should NOT be included. UPL payments made on a state fiscal year basis should be reported in Section C of the survey.
Note D - Should include other Medicare cross-over payments not included in the paid claims data reported above. This includes payments paid based on the Medicare cost report settlement (e.g., Medicare Graduate Medical Education payments).
Note E - Medicaid Managed Care payments should include all Medicaid Managed Care payments related to the services provided, including, but not limited to, incentive payments, bonus payments, capitation and sub-capitation payments.

J. Transplant Facilities Only: Organ Acquisition Cost In-State Medicaid and Uninsured

Cost Report Year (01/01/2019-12/31/2019) COFFEE REGIONAL MEDICAL CENTER

		Total Organ Acquisition Cost	Additional Add-In Intern/Resident Cost	Total Adjusted Organ Acquisition Cost	Revenue for Medicaid/ Cross-Over / Uninsured Organs Sold	Total Useable Organs (Count)	In-State Medicaid FFS Primary		In-State Medicaid Managed Care Primary		In-State Medicare FFS Cross-Overs (with Medicaid Secondary)		In-State Other Medicaid Eligibles (Not Included Elsewhere)		Uninsured	
							Charges	Useable Organs (Count)	Charges	Useable Organs (Count)	Charges	Useable Organs (Count)	Charges	Useable Organs (Count)	Charges	Useable Organs (Count)
		Cost Report Worksheet D-4, Pt. III, Col. 1, Ln 61	*Add-On Cost Factor on Section G, Line 133 x Total Cost Report Organ Acquisition Cost*	*Sum of Cost Report Organ Acquisition Cost and the Add-On Cost*	*Similar to Instructions from Cost Report W/S D-4 Pt. III, Col. 1, Ln 66 (substitute Medicare with Medicaid/ Cross-Over & uninsured). See Note C below.*	*Cost Report Worksheet D-4, Pt. III, Line 62*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Hospital's Own Internal Analysis*	*From Hospital's Own Internal Analysis*
	Organ Acquisition Cost Centers (list below):															
1	Lung Acquisition	$0.00	$ -	$ -		0										
2	Kidney Acquisition	$0.00	$ -	$ -		0										
3	Liver Acquisition	$0.00	$ -	$ -		0										
4	Heart Acquisition	$0.00	$ -	$ -		0										
5	Pancreas Acquisition	$0.00	$ -	$ -		0										
6	Intestinal Acquisition	$0.00	$ -	$ -		0										
7	Islet Acquisition	$0.00	$ -	$ -		0										
8		$0.00	$ -	$ -		0										
9	**Totals**	$ -	$ -	$ -	$ -	-	$ -	-	$ -	-	$ -	-	$ -	-	$ -	-
10	**Total Cost**							-		-		-		-		-

Note A - These amounts must agree to your inpatient and outpatient Medicaid paid claims summary, if available (if not, use hospital's logs and submit with survey).
Note B: Enter Organ Acquisition Payments in Section H as part of your In-State Medicaid total payments.
Note C: Enter the total revenue applicable to organs furnished to other providers, to organ procurement organizations and others, and for organs transplanted into non-Medicaid / non-Uninsured patients (but where organs were included in the Medicaid and Uninsured organ counts above). Such revenues must be determined under the accrual method of accounting. If organs are transplanted into non-Medicaid/non-Uninsured patients who are not liable for payment on a charge basis, and as such there is no revenue applicable to the related organ acquisitions, the amount entered must also include an amount representing the acquisition cost of the organs transplanted into such patients.

K. Transplant Facilities Only: Organ Acquisition Cost Out-of-State Medicaid

Cost Report Year (01/01/2019-12/31/2019) COFFEE REGIONAL MEDICAL CENTER

		Total Organ Acquisition Cost	Additional Add-In Intern/Resident Cost	Total Adjusted Organ Acquisition Cost	Revenue for Medicaid/ Cross-Over / Uninsured Organs Sold	Total Useable Organs (Count)	Out-of-State Medicaid FFS Primary		Out-of-State Medicaid Managed Care Primary		Out-of-State Medicare FFS Cross-Overs (with Medicaid Secondary)		Out-of-State Other Medicaid Eligibles (Not Included Elsewhere)	
							Charges	Useable Organs (Count)	Charges	Useable Organs (Count)	Charges	Useable Organs (Count)	Charges	Useable Organs (Count)
		Cost Report Worksheet D-4, Pt. III, Col. 1, Ln 61	*Add-On Cost Factor on Section G, Line 133 x Total Cost Report Organ Acquisition Cost*	*Sum of Cost Report Organ Acquisition Cost and the Add-On Cost*	*Similar to Instructions from Cost Report W/S D-4 Pt. III, Col. 1, Ln 66 (substitute Medicare with Medicaid/ Cross-Over & uninsured). See Note C below.*	*Cost Report Worksheet D-4, Pt. III, Line 62*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*
	Organ Acquisition Cost Centers (list below):													
11	Lung Acquisition	$ -	$ -	$ -	$ -	0								
12	Kidney Acquisition	$ -	$ -	$ -	$ -	0								
13	Liver Acquisition	$ -	$ -	$ -	$ -	0								
14	Heart Acquisition	$ -	$ -	$ -	$ -	0								
15	Pancreas Acquisition	$ -	$ -	$ -	$ -	0								
16	Intestinal Acquisition	$ -	$ -	$ -	$ -	0								
17	Islet Acquisition	$ -	$ -	$ -	$ -	0								
18		$ -	$ -	$ -	$ -	0								
19	**Totals**	$ -	$ -	$ -	$ -	-	$ -	-	$ -	-	$ -	-	$ -	-
20	**Total Cost**							-		-		-		-

Note A - These amounts must agree to your inpatient and outpatient Medicaid paid claims summary, if available (if not, use hospital's logs and submit with survey).
Note B: Enter Organ Acquisition Payments in Section I as part of your Out-of-State Medicaid total payments.

L. Provider Tax Assessment Reconciliation / Adjustment

An adjustment is necessary to properly reflect the Medicaid and uninsured share of the provider tax assessment for some hospitals. The Medicaid and uninsured share of the provider tax assessment collected is an allowable cost in determining hospital-specific DSH limits and, therefore, can be included in the DSH examination survey. However, depending on how your hospital reports it on the Medicare cost report, an adjustment may be necessary to ensure the cost is properly reflected in determining your hospital-specific DSH limit. For instance, if your hospital removed part or all of the provider tax assessment on the Medicare cost report, the full amount of the provider tax assessment would not have been apportioned to the various payers through the step down allocation process, resulting in the Medicaid and uninsured share being understated in determining the hospital-specific DSH limit. If your hospital needs to make an adjustment for the Medicaid and uninsured share of the provider tax assessment, please fill out the reconciliation below, and submit the supporting general ledger entries and other supporting documentation to Myers and Stauffer, LC along with your hospital's DSH examination surveys.

Cost Report Year (01/01/2019-12/31/2019) COFFEE REGIONAL MEDICAL CENTER

Worksheet A Provider Tax Assessment Reconciliation:

			Dollar Amount	W/S A Cost Center Line	
1	Hospital Gross Provider Tax Assessment (from general ledger)*		$ 1,159,200		
1a	*Working Trial Balance Account Type and Account # that includes Gross Provider Tax Assessment*		Expense	7701-3514	*(WTB Account #)*
2	Hospital Gross Provider Tax Assessment Included in Expense on the Cost Report (W/S A, Col. 2)		$ 1,159,200	Administrative and General	*(Where is the cost included on w/s A?)*
3	Difference (Explain Here ---------->)		$ -		
	Provider Tax Assessment Reclassifications (from w/s A-6 of the Medicare cost report)				
4	*Reclassification Code*				*(Reclassified to / (from))*
5	*Reclassification Code*				*(Reclassified to / (from))*
6	*Reclassification Code*				*(Reclassified to / (from))*
7	*Reclassification Code*				*(Reclassified to / (from))*
	DSH UCC ALLOWABLE - Provider Tax Assessment Adjustments (from w/s A-8 of the Medicare cost report)				
8	*Reason for adjustment*	Medicare non allowable expense	$ (1,159,200)		*(Adjusted to / (from))*
9	*Reason for adjustment*				*(Adjusted to / (from))*
10	*Reason for adjustment*				*(Adjusted to / (from))*
11	*Reason for adjustment*				*(Adjusted to / (from))*
	DSH UCC NON-ALLOWABLE Provider Tax Assessment Adjustments (from w/s A-8 of the Medicare cost report)				
12	*Reason for adjustment*				
13	*Reason for adjustment*				
14	*Reason for adjustment*				
15	*Reason for adjustment*				
16	Total Net Provider Tax Assessment Expense Included in the Cost Report		$ -		

DSH UCC Provider Tax Assessment Adjustment:

17	Gross Allowable Assessment Not Included in the Cost Report		$ 1,159,200
	Apportionment of Provider Tax Assessment Adjustment to Medicaid & Uninsured:		
18	Medicaid Hospital	**Charges Sec. G**	134,427,485
19	Uninsured Hospital	**Charges Sec. G**	42,042,893
20	Total Hospital	**Charges Sec. G**	386,692,277
21	Percentage of Provider Tax Assessment Adjustment to include in DSH Medicaid UCC		34.76%
22	Percentage of Provider Tax Assessment Adjustment to include in DSH Uninsured UCC		10.87%
23	Medicaid Provider Tax Assessment Adjustment to DSH UCC		$ 402,978
24	Uninsured Provider Tax Assessment Adjustment to DSH UCC		$ 126,033
25	Provider Tax Assessment Adjustment to DSH UCC		**$ 529,011**

** Assessment must exclude any non-hospital assessment such as Nursing Facility.*

*** The Gross Allowable Assessment Not Included in the Cost Report (line 17, above) will be apportioned to Medicaid and uninsured based on charges sec. g unless the hospital provides a revised cost report to include the amount in the cost-to-charge ratios and per diems used in the survey.*